for 10 years. Staff Sergeant Slay was assigned to the 2d Amphibious Assault Vehicle Battalion, 3d Battalion, 1st Marine Regiment, Regimental Combat Team 1, 1st Marine Division, Camp Pendleton, CA. Staff Sergeant Slay was killed in the line of duty during Operation Iraqi Freedom while conducting combat operations in the Al Anbar Province.

Russell Slay leaves behind his father Roy Slay, his mother Donna Slay, and his step mother Peggy Slay, along with his two children Morgan, 9, and Walker, 5, who live in Humble.

I know his parents, family and friends are devastated by this loss, but they should be proud of the great man Russell Slay had become and that he died a hero while serving his country. America does not forget those who make the ultimate sacrifice.

His loss will be felt by all of Houston, and I ask that you remember the Slay family in your thoughts and prayers.

CELEBRATING NATIONAL HOMECARE AND HOSPICE MONTH

HON. DEBORAH PRYCE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 19, 2004

Ms. PRYCE of Ohio. Mr. Speaker, I rise today to recognize the tremendous value homecare and hospice represents for American families. Homecare provides a family-friendly, clinically proven way of receiving quality healthcare for millions of Americans where they prefer to receive care—at home. November, National Homecare and Hospice Month, is an opportunity to recognize the importance of home care as an essential component of healthcare in my home state of Ohio and throughout the United States.

This important segment of the health care continuum allows patients with medical needs to remain in their homes, including those who are recovering, disabled, chronically or terminally ill who need medical, nursing, social, or therapeutic treatment. Homecare and hospice care represent a family value and a value for families. It's about quality health care and quality of life for millions of households across the United States.

Recent studies of homecare services show that homecare for selected conditions can shorten inpatient hospital stays, reduce the overall cost of care without compromising outcomes, and can improve patient and caregiver satisfaction.

As the American population ages, homecare is expected to grow in the years ahead. Fortunately, advances in technology allow virtually every service short of surgery to be delivered at home. This is good news for our nation's seniors and their families. And it's good news for younger generations who will benefit from continued advancements in technology to further improve the quality and accessibility of homecare.

Homecare and hospice care is an especially important option for people facing terminal illness. These individuals and their families are faced with enormous challenges in dealing with the fear that goes along with such a frightening diagnosis. Hospice treats the person, not the disease. It allows terminally ill patients and their families to experience the end of life together in the comfort and security of their homes or a home-like setting.

While homecare and hospice care serve a critical purpose for our nation's elderly population, these services also provide much-needed care for children with lifethreatening conditions and their families. Today in the United States, about one million children are living with life-threatening conditions and a staggering 55,000 children die each year. In an effort to make improvements to our system that treats terminally ill children, I introduced H.R. 3127, the Compassionate Care for Children Act, in the 108th Congress. This bill will help insure children with life-threatening illnesses have access to the treatments and care that they need and deserve, including hospice, palliative and curative care.

In honor of patients, their families, and caregivers in Ohio and throughout the United States, I join my colleagues in celebrating National Homecare and Hospice Month.

IMPROVING VETERANS EYE CARE

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 19, 2004

Mr. BURGESS. Mr. Speaker, as health care consumers we all expect the highest quality of care available when we visit a health care facility. However, a recent decision by the Department of Veteran Affairs subjects our Nation's veterans to a lower standard of care that 49 out of 50 states permit. This directive, which permits optometrists to perform laser eye surgery in VA health facilities, only confuses the public and veterans about the difference between ophthalmologists and optometrists. In a recent survey of veterans who use the VA health system, 30 percent mistakenly thought optometrists were medical doctors. Further, over 95 percent of veterans think it is important to have a licensed medical doctors specializing in eye care performing their eye surgery in the VA. Our nation's veterans deserve better.

I submit the following for the RECORD:

Optometrists attend four-year Schools of Optometry but have no required post-graduate training or national board certification process. Beyond state optometric licensure, there is no ongoing, national re-certification process to assure the public of the competency of optometrists who are already in practice. In contrast, ophthalmologists are medical doctors who attend four years of medical school. They then complete one post-graduate year of general medical or surgical internship, three years of an ophthalmology residency training program, a national Board certification examination, and mandatory re-certification testing.

EDUCATION

Optometry School (4 years in length): Curriculum includes contact lenses, optics, vision sciences, sensory processing, vision therapy, practice management etc., and courses related to basic medical sciences and eye diseases. Average hours of course work based on a comparison of SUNY Optometry School are 597.3 hours. Optometrists have an average of 335.5 hours of lab and instruction on ocular disease and management.

Medical School (4 years in length): Curriculum focuses on fundamental principles of medicine and its underlying scientific concepts, including required courses on anatomy, biochemistry, genetics, physiology, microbiology and immunology, pathology, pharmacology and therapeutics and preventive medicine, including laboratory. Clinical sciences encompass all organ systems, including the important aspects of preventive, acute, chronic, continuing, rehabilitative and end-of-life care. Clinical experience includes family and internal medicine, obstetrics, gynecology, pediatrics, psychiatry and surgery. Average hours of coursework based on average across medical schools are 1, 436.10. In addition, ophthalmologists spend a minimum of 626 hours (not including medical school) of lab and instruction on ocular disease and management.

MANDATORY POST-GRADUATE TRAINING

Optometry: There is no mandatory post-graduate training. About 15% go on to an optional 1yr training program.

Ophthalmology (Additional 4 years in training): To become an ophthalmologist after medical school, one must complete 1 year of general medical or surgical internship, and 3 years of an ophthalmology residency training program. About 40% go on to a 1 or 2 year fellowship program to concentrate training and experience in a particular subspecialty. The Accreditation Council in Graduate Medical Education has standards in place for patient care responsibilities, minimum outpatient visits and minimum surgical numbers for residency programs.

CLINICAL EXPERIENCE DURING MANDATORY EDUCATION AND TRAINING

Optometry: A 1995–1996 survey of optometric curriculum found a range of 1,215 to 2,240 hours, with an average of 1,910 hours, for clinical experience across schools (a more recent study was not able to be located). During training, optometrists have no minimum requirements for the number of patient visits with ocular diseases or ocular surgical operative experience. There is also no requirement for systemic disease consultation.

Ophthalmology: Based on an estimate of an average of 60 hours per week (including on-call duty the maximum duty hours for residents is 80 hours per week) x 48 weeks x 5 years, at least 17,280 hours are for clinical experience throughout medical school internship and residency for ophthalmologists. During training, the ACGME requires that ophthalmologists have a minimum of 3,000 outpatient visits with a broad range of disease presentation and they must perform and assist at sufficient surgery to be skilled. There are also requirements for systemic disease consultation.

PROFESSIONAL REGULATION

Optometry: There is no national ''Board certification'' process in place for optometry. Beyond state licensure, there is no ongoing ''Board certification'' process to assure the public of the competency of optometrists who are already in practice.

Ophthalmology: There is a Board certification process to assure the public of successful completion of an accredited course of education and examination process by certified ophthalmologists. In addition to state licensure, an ongoing process, Maintenance of Certification, requires renewal of certification every 10 years for ophthalmologists certified in 1992 or later, and many other ophthalmologists voluntarily enter this process.

This data has been collected from SUNY State College of Optometry, Liaison Committee on Medical Education Accreditation Standards, U.S. Department of Education and ACGME.